Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UMC AT BRACKENRIDGE

Respondent Name
SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 22, 2013

MFDR Tracking Number
M4-13-3089-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As you can see on the attached documentation, the insurance processed the claim as a non-network provider. UMC at BRACKENRIDGE is not a part of a network."

Amount in Dispute: $ 643.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services were denied due ot the facility not being authorized to provide treatment to an HCN claimant. This facility is not contracted for the Texas CorCare Certified Network nor did they receive an Out of Network authorization... The DWC/MDR does not have jurisdiction to decide this dispute because [injured employee's] claim is covered under the carrier's 1305 Certified Network.

Response Submitted by: CorVel Corporation

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
July 30, 2012 through August 27, 2012	97110 x 3	$643.50	$0.00

BACKGROUND

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

FINDINGS AND DECISION

Issue

1. Did the requestor receive a referral approval from the certified network to treat the injured employee?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." The requestor therefore has the burden to prove that the condition(s) outlined in the Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The following are the Division's findings.

1. Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   Texas Insurance Code Section 1305.103 requires, in pertinent part, that "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network..."

   The requestor has the burden to prove that it obtained the appropriate network approved referral for the out-of-network healthcare it provided. The requestor, in its position summary states "As you can see on the attached documentation, the insurance processed the claim as a non-network provider. UMC at BRACKENRIDGE is not a part of a network." Review of the submitted documentation finds that out-of-network provider provided treatment to an injured employee enrolled in a certified network and insufficient documentation was submitted to support that a referral from the injured employee's treating doctor that has been approved by the network was obtained. The Division concludes that the requestor did not receive a referral approval from the Network to treat the injured employee, thereby failing to meet the requirements of Texas Insurance Code Section 1305.103.
2. The requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Manager	**October 30, 2014** Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.